SLEEP SCIENCE CLINICS (TEXAS)

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SLEEP QUESTIONNAIRE

NAME: _____ _____ _____
FIRST NAME MI LAST NAME

DOB (mm/dd/yy): _____ _____ Age: _____ Gender: Male ☐ Female ☐

Height: _____ Feet: _____ Inches: _____ Neck Size: _____

Tally Risk Points

Neck Size
+2 Male ≥ 16.5
+2 Female ≥ 15.0

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION- ANSWER ALL QUESTIONS

HAVE YOU BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?

High Blood Pressure	Yes ○ No ○	Stroke	Yes ○ No ○		
Heart Disease	Yes ○ No ○	Depression	Yes ○ No ○		
Diabetes	Yes ○ No ○	Sleep Apnea	Yes ○ No ○		
Lung Disease	Yes ○ No ○	Nasal Oxygen Use	Yes ○ No ○		
Insomnia	Yes ○ No ○	Restless Leg Syndrome	Yes ○ No ○		
Narcolepsy	Yes ○ No ○	Morning Headaches	Yes ○ No ○		
Sleeping Medication	Yes ○ No ○	Pain Medication e.g., Vicodin, Oxycontin	Yes ○ No ○		

Co-morbidities
+1for each Yes response

Score ☐

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 =would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (theater, meeting, etc.)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Epworth Score TOTAL the values from all 8 questions,
If 11 or less **Score= 0**
If 12 or more **Score= 2**

Score ☐

Assign points for each of the first three responses

Frequency: **0–1 times/week** **1–2 times/week** **3–4 times/week** **5–7 times/week**

On average in the past month, how often have you snored or been told that you snored? ☐

Never ☐ Rarely ☐ + 1 Sometimes ☐ + 2 Frequently ☐ +3 Almost always ☐ +4

Do you wake up choking or gasping? ☐

Never ☐ Rarely ☐ + 1 Sometimes ☐ + 2 Frequently ☐ +3 Almost always ☐ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping? ☐

Never ☐ Rarely ☐ + 1 Sometimes ☐ + 2 Frequently ☐ +3 Almost always ☐ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable? ☐

Never ☐ Rarely ☐ + 1 Sometimes ☐ + 2 Frequently ☐ +3 Almost always ☐ +4

Signature	(Area Code) Phone Number	**Total all 6 boxes from above**	**POINT TOTAL**
		If point total = 4 to 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	☐